Filed for intro on 01/17/2002

SENATE BILL 2390
By Graves

AN ACT to amend Tennessee Code Annotated, Title 56, relative to policies and procedures used in utilization review processes for the diagnosis and treatment of mental health care and chemical dependency disorders.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-6-702, is amended by deleting subsections (4) and (5) and substituting instead the following new subsections:

(4) Improve communications and knowledge of benefit plan requirements among all parties concerned before expenses are incurred;

(5) Ensure that utilization review agents and procedures maintain and safeguard the confidentiality of all health-related records, especially mental health and chemical dependency disorders, in accordance with applicable laws and requirements of nationally recognized review accrediting bodies such as the Utilization Review Accreditation Commission (URAC); and

(6) Eliminate administrative barriers to accessing care by restricting excessive and unnecessary paperwork demands on providers of care.

SECTION 2. Tennessee Code Annotated, Section 56-6-703(4)(A), is amended by adding the following sentence at the end of the item:

Since utilization review programs employ a system of reviewing the clinical or medical necessity of care in order to determine the appropriate allocation of health resources or services utilized and do not concern themselves with benefit design per se, the standards of care expected of these utilization review programs shall apply to all forms of health insurance, managed care programs, or other forms of third party payor indemnification, including self-insured health care programs;

SECTION 3. Tennessee Code Annotated, Section 56-6-704(a), is amended by adding the following new sentence at the end of the subsection:

Utilization review programs for mental health and chemical dependency care must comply with the most recent requirements of nationally recognized utilization review accrediting bodies (i.e., URAC).

SECTION 4. Tennessee Code Annotated, Section 56-6-704(b), is amended by deleting the word "and" at the end of subdivision (2), deleting the period (.) at the end of subdivision (3) and substituting instead the language "; and", and by adding a new subdivision as follows:

(4) Utilization review programs for mental health and chemical dependency care must publicly publish and distribute upon request to consumers, providers, and facilities a description of reviews standards and procedures for all levels of care, the specific criteria and standard of care used in conducting any utilization review procedures, and the specific interpretation of these guidelines or protocols in clinical decision-making. Clinical protocols and criteria for admission, continued stay, changing levels of care, and discharge from care used in utilization review processes must be objective and based on sound clinical principles and processes.

SECTION 5. Tennessee Code Annotated, Section 56-6-705(a)(4)(A), is amended by adding the following new language at the end of the item:

For mental health and chemical dependency care, the reviewer in these appeal determinations must be both licensed in an appropriate mental health discipline and of

the same professional discipline and specialty area as the provider seeking authorization for the care denied;

SECTION 6. Tennessee Code Annotated, Section 56-6-705(a), is amended by deleting the word "and" at the end of subdivision (8), deleting the period (.) at the end of subsection (9) and by substituting instead the language "; and", and by adding a new subdivision as follows:

(10) For mental health and chemical dependency care, a greater intensity or frequency of care often requires more focused and specified utilization review. Specifically, inpatient, residential, intensive outpatient programs, partial hospitalization programs, wrap-around services and other programs that require two (2) or more clinical service hours of care per day may require precertification of care and more intensive utilization review procedures. Prior authorization shall not be required for emergency services of any sort, either for in-network or out of network providers or facilities. There shall be no utilization review procedures of any sort for outpatient medication management by psychiatrists. There shall be no precertification of care needed by in-network providers or facilities for the initial outpatient diagnostic interview, provided it does not exceed two (2) hours of care. For traditional outpatient services for in-network providers or facilities, there shall be no precertification or registration of care required, nor any requirement to access care through any sort of gatekeeper, primary care physician or other entity to obtain authorization for care. Furthermore, for these in-network providers or facilities providing traditional outpatient services of not more than two (2) hours per day, there shall be no utilization review procedures permitted other than providing identifying information, the multiaxial diagnoses, and the kind and frequency of care being rendered. For outpatient services rendered by out of network providers or facilities, the health plan may require an initial precertification or registering of care procedure that is brief and does not discourage care. For these out of network providers or facilities rendering traditional outpatient services of not more than two (2)

hours per week, there shall be no utilization review procedures permitted for the first twenty-six (26) outpatient sessions in any calendar year. Should the length of care for outpatient services by out of network providers or facilities exceed twenty-six (26) sessions in any calendar year, reasonable and appropriate utilization review may occur at a rate not to exceed one (1) review every three (3) months for the remainder of the calendar year provided the additional care authorized does not exceed two (2) additional outpatient appointments per week. Reasonable and appropriate utilization review for these occasions means restricting the review of care to one eight by eleven (8x11) page of information containing identifying information, multiaxial diagnoses, symptoms, medication information, if applicable, and the kind and frequency of care requested.

SECTION 7. Nothing in this act shall apply to the TennCare program.

SECTION 8. This act shall become law upon becoming a law, the public welfare requiring it.